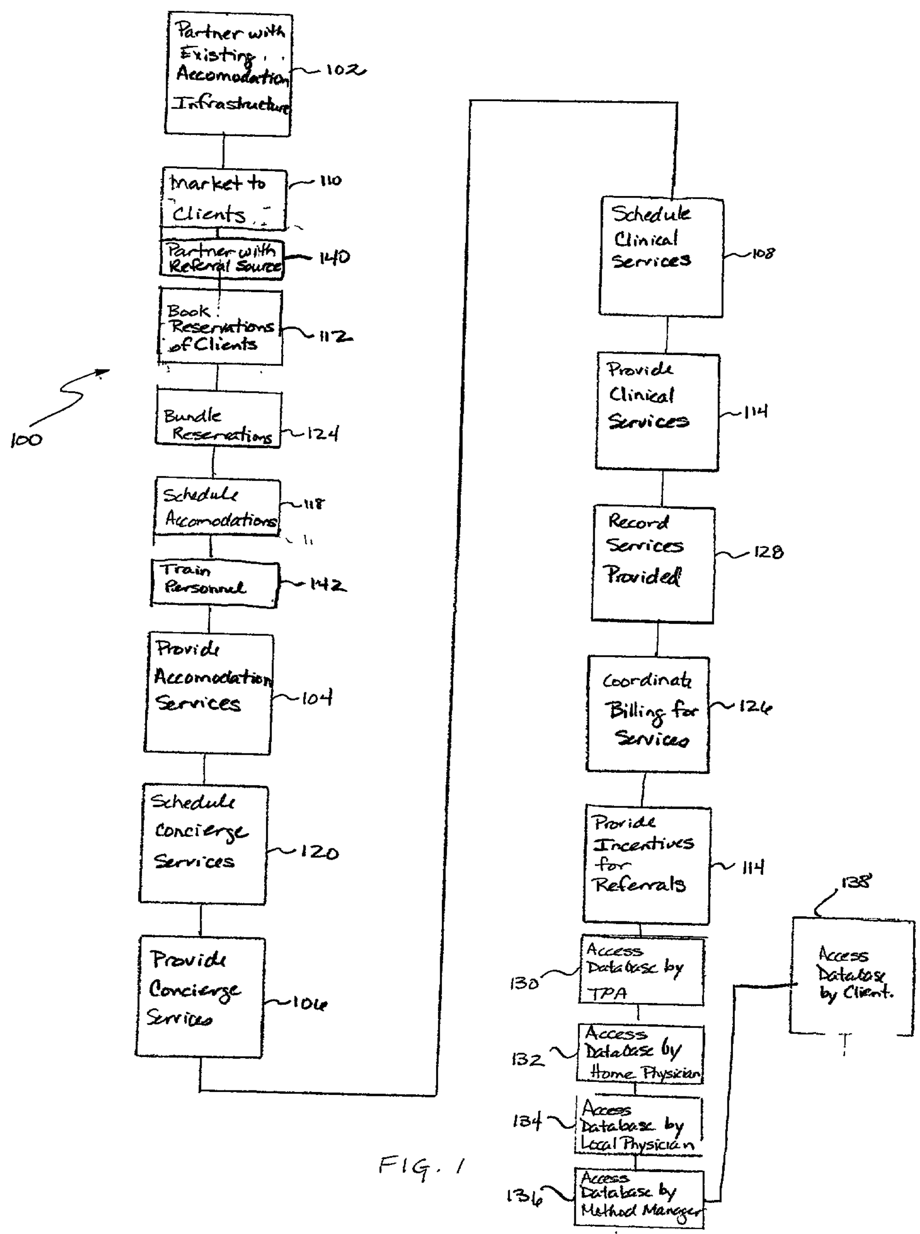

Partner with Existing Accomodation Infrastructure
102
Market to Clients
110
Partner with Referral Source
140
Book Reservations of Clients
112
Bundle Reservations
124
Schedule Accomodations
118
Train Personnel
142
Provide Accomodation Services
104
Schedule Concierge Services
120
Provide Concierge Services
106
100
Schedule Clinical Services
108
Provide Clinical Services
114
Record Services Provided
128
Coordinate Billing for Services
126
Provide Incentives for Referrals
114
Access Database by TPA
130
Access Database by Home Physician
132
Access Database by Local Physician
134
Access Database by Method Manager
136
Access Database by Client.
138

FIG. 1

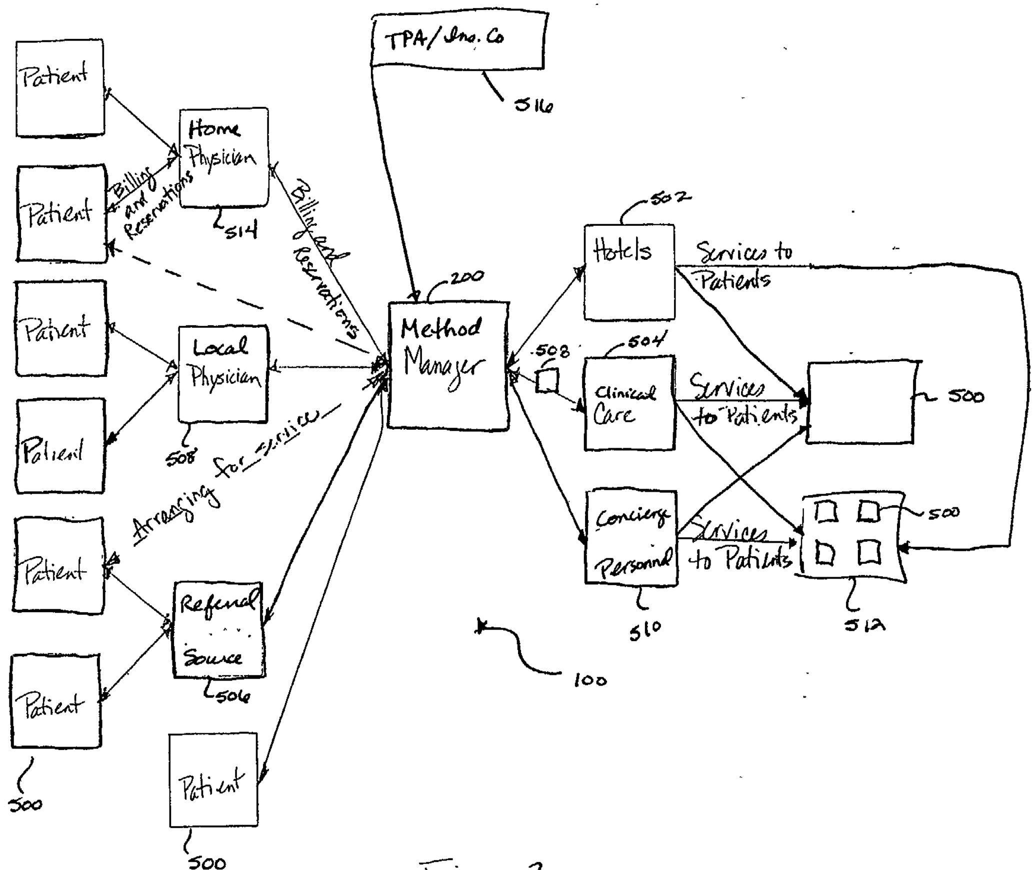


Fig 2

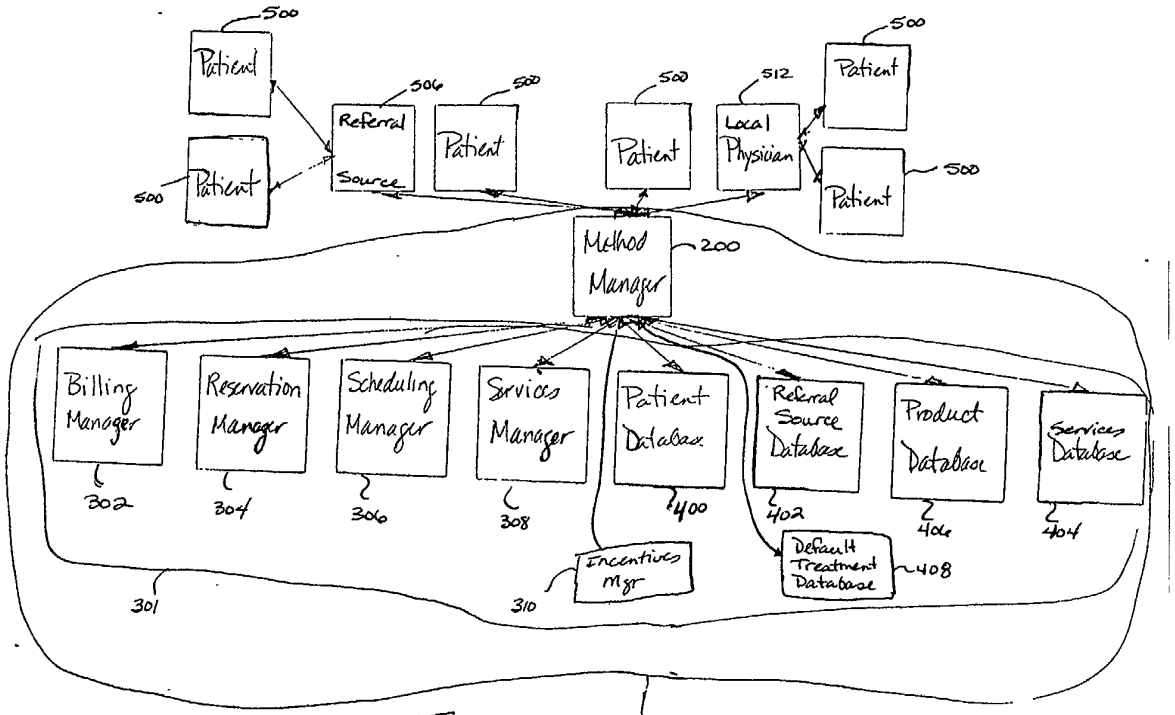

500
Patient
500
Patient
506
Referral Source
500
Patient
500
Patient
512
Local Physician
500
Patient
500
Patient
Method Manager
200
Billing Manager
302
Reservation Manager
304
Scheduling Manager
306
Services Manager
308
Patient Database
400
Referral Source Database
402
Product Database
406
Services Database
404
Incentives Mgr
310
Default Treatment Database
408
301
300

Fig. 3

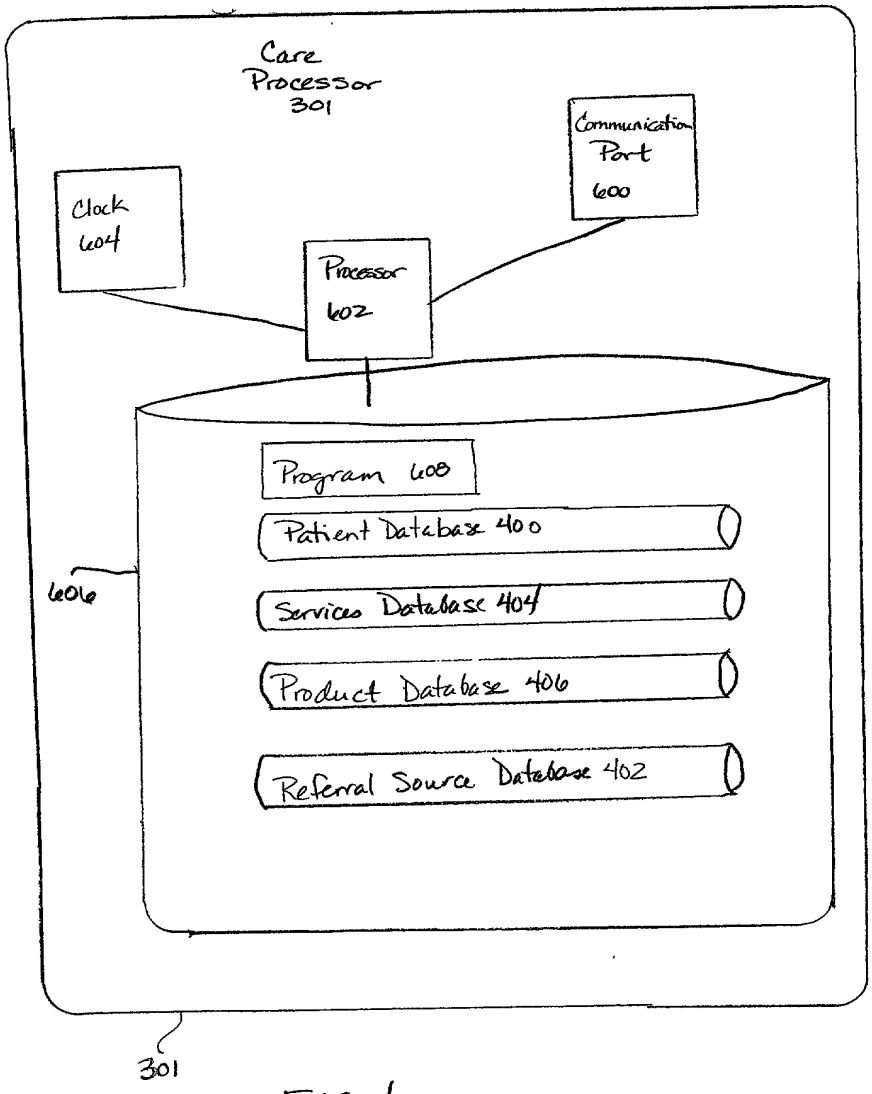

Care Processor 301
Communication Port 600
Clock 604
Processor 602
Program 608
Patient Database 400
Services Database 404
Product Database 406
Referral Source Database 402
606
301

FIG. 4

Patient Identifier 614	Patient Name 618	Patient Address 620	Geographical Location for Treatment and/or After Care 622	Medical Facility Identifier 624	Local Physician Identifier 626	Local Physicial Contact Information 628	TPA/Insurance Company Identifier 630	Home Physicial Identifier 632	Home Physician Contact Information 634	Expected Start Date Identifier 636	Expected Stop Date Identifier 640	Expected Length of Stay and Accomodation 642	Medical Procedure or Care Identifer 644

An Accomodation Preferences Identifier 646	Concierge Services Preferences 648	Personal Emergency Contact Information 650	Billing Status Identifier 652	Referral Source Identifier 654	Bundle Identifier 656	Reservation Identifier 616	Patient Birth Date 658	Patient Sex Identifier 638	Patient Allergies 739	Anniversary of the Procedure/Recovery 660	Default After Care Protocol and Notes 662	Prescribed After Care Protocol and Notes 664	Medical Record Information 666

FIG. 5

Referral Source Identifier 654	Referral Source Name 672	Referral Source Contact Information 674	Billing Type Information 676	Billing Status Information 652	Incentive Information 680	Client Patient Identifier Information 614	Medical Procedure or Care Identifier 644	Incentives Received Identifier 678	Incentives Due Identifier 682	Referral Information 683

FIG. 6

Patient Identifier 614	Patient Name 618	Reservation Code 616	Bundle Identifier 656	Service Type Identifier 692	Service Provider Identifier 690	Time Identifier 694	Date Identifier 696	Cost Identifier 698	Billing Status Identifier 652

FIG. 7

Product Identifier 704	Product Price 706	Availability Identifier 708	Product Ingredients 710	Prescribed Uses for the Product 712	Medical Procedure or Treatment Identifier 644	Provider Identifier 714

FIG. 8

Medical Procedure or Treatment Identifier 644	Medication Type Identifier 724	Medication Dosage Identifier 726	Treatment Type Identifier 728	Treatment Practice Identifier 730

FIG. 9

PRACTICE PROFILE

Prepared by	Date.

Institution
Location
Address.

City	State	Zip

	Referral Potential				Attitude
	Q1	Q2	Q3	Q4	
Pats					

Tel. (Switch)	
Fax	
Website	

Key Personnel					
Contact	Title	First name	Initials.	Last Name	Position Title

Types and Volumes of Patients	Services Required	Special Needs

Referral Process	Agreed Action (What)	Who?	When?

Marketing Process	Agreed Action (What)	Who?	When?

Training Process	Agreed Action (What)	Who?	When?

Relationship Building	Agreed Action (What)	Who?	When?

FIG. 10

FIG. 11A

TITLE: **TUBE FEEDING MANAGEMENT PROTOCOL**

PURPOSE: To outline the nursing management of patients receiving continuous. intermit tent, or cyclic enteral tube feedings via nasogastric, gastrostomy, duodenostomy, or jejunostomy tube.

LEVEL OF PERSONNEL: RN LPN

PURPOSE: Tube feedings are employed to meet nutritional needs including hydration requirements when normal oral intake is altered or contraindicated. The potential for tube displacement puts these patients at risk for aspiration **pneumonia,** or peritonitis.

MD ORDER

1. Validate that tube feeding order states formula, volume, strength, rate, time span, and method of delivery (i.e. continuous, cyclic, bolus or gravity drip).
2. Measure, at time of feeding tube insertion, the length of visible tube and record on NPR.

ASSESSMENT

4. Assess for tube placement q 8 hours and before each intermittent feeding or medicaflon administration, using at least two of the following measures:
   - a- measure and compare length of visible tube to initial measurement
   - b. aspirate gastric or small bowel contents (5-lOml, observe for appropriate color and consistency)
   - C. instill 10 ml of air into tube while auscultating stomach (gastric only)
5. Assess gastrostomy/jejunostomy site q 24 hours for:
   - a. leakage of formula around tube
   - b. signs of infection (redness. induration, purulent drainage)
6. Assess patient's fluid balance q 24 hours:
   - a. compare I/O, note fluid imbalances
   - b. monitor weight changes
   - c. monitor lab values (electrolytes, BUN, Cr.)
7. Assess general abdominal/digestive status q 8 shift:
   - a. assess bowel sounds
   - b. observe for signs/symptoms of feeding intolerance: repeated nausea/vomiting, cramping. diarrhea or gastric residual >lOOml/l hour.

FIG. 11B

8. Weigh patient q AM, unless otherwise ordered.

9. Maintain I&O q 8 hours.

REPORTABLE CONDITIONS

10. Report promptly to MD:

a. suspected displacement of feeding tube
b. suspected aspiration, i.e. SOB, elevated temperature
c obstruction of feeding tube
d. abdominal distention, nausea/vomiting, cramping, diarrhea, constipation
e. fluid-electrolyte imbalance
f. gastric residual >120 ml for 2 hours for adults, 0-3 month >30, 3-12 months >45, 14yr+> 60, if on bolus> 1/3 of previous feed.
g. suspected formula leakage around gastrostomy or jejunostomy
h. temperature >101°F.

11. Administer all formulas at room temperature.

12. Elevate HOB 45 degrees during feeding and for 1 hour following bolus or gravity feed.

13. Flush tube with 5ml for pedi, 10 ml for adult of warm water when feeding is interrupted, stopped, or after each intermittent feeding.

14 Flush tube q 4 **hours** with 5ml of warm tap water if feeding is continuous.

15. Stop **gastric** tube feeding it patient is placed flat or in Trendelenberg.

16.. Measure gastrostomy residual q 4 hours or before every intermittent feeding:

a. if residual is> 100 ml, HOLD feeding for 1 hour.
b. Recheck residual, if still > than 100 ml, HOLD and notify **MD.**
Reinstill aspirate.

17. Hold feeding for 1 **hour** if patient is nauseated, vomiting, or abdominal distention is present, if symptoms do not improve, notify MD.

INFECTION

18. Only hang a 4 **hour** supply of formula, do not leave open formula containers at room temperature for **more than 1 hour.**

19. Change formula bag/tubing q 48 **hours.**

FIG. 12A

TITLE: VENIPUNCTURE FOR BLOOD SAMPLING

LEVEL OF PERSONNEL: RN, LPN,

DESIGNATED CLINICAL AREA: All

PURPOSE: To obtain routine blood samples.

APPLICABLE POLICY *STATEMENTS*:

Individuals must successfully complete the training program to perform venipuncture for blood sampling.

A physician's order must be obtained for each test.

CRITICAL ELEMENTS:

1. Use of site in antecubital fossa is preferred if a vein is easily palpable. If a vein is not eaasily identified, sites in the lower arm or hand may be used, but only as a last resort.
2. Blood samples should not be drawn from an arm with a continuous IV infusion. For patients who should not have venipuncture performed in one arm, notify RN caring for patient, if applicable. IV infusion should be turned off in order to be able to draw blood.

EQUIPMENT:

Venoject (may substitute a #23 gauge butterfly needle and syringe)
Appropriate specimen tube with labels
Alcohol swabs
Gauze sponge
Tourniquet
Disposable gloves
Plastic bags for specimen transport
Appropriate lab requisitions

NURSING ACTIONS:	SPECIAL CONSIDERATIONS:
1. Identify the patient.	
2. Position patient's arm.	
3. Select site for venipuncture. (Figure 1)	
4. Apply tourniquet proximal to chosen site.	4. Vein should be distinct-easily visible

FIG. 12B

	and/or palpable. Tourniquet should be tight enough to obstruct venous flow, but, not arterial flow (radial pulse should be palpable).
If vein is not prominent:	
a. Have patient open and close hand, making a fist, no more than 2 times.	a. Opening and closing the fist more than 2 may increase lactic acid.
b. Lightly tap vein site.	
c. Take tourniquet off, then place extremity in a dependent position for a few minutes.	c. Promotes venous distention.
d. If necessary, apply moist heat for a few minutes.	d. Use wash cloth moistened with warm tap water.
e. Reapply tourniquet.	
5. Cleanse site and surrounding area with alcohol. Repeat if skin is unusually soiled. Using second clean alcohol sponge, wipe the site once with a downward stroke.	5. Allow to air dry completely to prevent burning at site and prevent hemolysis. Alcohol mixing with blood causes hemolysis.
6. Put on gloves.	
7. Stabilize the extremity and using thumb, hold skin taut below prepped area just distal to intended puncture site.	
8. At a 15 degree angle, insert the needle, bevel up, through the skin parallel to vein.	8. Parallel approach decreases rolling of vessel.

FIG. 12C

NURSING ACTIONS:	SPECIAL CONSIDERTIONS:
9. Butterfly needle: Withdraw desired amount of blood and then release tourniquet. Straight needle with vacutainer: Remove tube immediately after filling And insert next tube.	9. Release of tourniquet prior to removal of needle prevents extravasation of blood into tissue or excessive bleeding from puncture site. Release of tourniquet just before blood Drawing is complete allows for a last "surge" of blood into specien tubes. However, if blood flow is sluggish, it is best to leave tourniquet in place until the desired amount of blood is obtained.
10a. Recommended order of filling multiple tubes: 1) Blood Cultures 2) Red top-no anticoag 3) Blue top 4) Purple top 5) Gray top 6) Green top	10a. The rule is to alawys collect blood in the tube containing anticoagulant last.
10b. Invert the tubes gently about 10 times. Withdrw desired amount of blood (ie., last tube almost filled). Then release tourniquet.	10b. Blood needs to be mixed with the additive in the tube for it to function properly.
11. When using the vacutainer, remove tube from needle holder to relieve vacuum before removing needle from vein.	
12. Place gauze sponge over puncture site, remove needle and then apply pressure over site until bleeding stops. Ask patient to keep arm straight.	12. Bending the arm might cause a hematoma.
13. Check venipuncture site before leaving room.	13. If hematoma develops, apply warm Moist soaks with wash cloth.
14. If butterfly needle and syringe is used, place blood in appropriate specimen tubes following above recommended guidelines. Label tubes, place in bags and send to lab with appropriate requisition.	

FIG. 12D

NURSING ACTIONS:

14. If butterfly needle and syringe is used, place blood in appropriate specimen tubes following above recommended guidelines. Label tubes, place in bags and send to lab with appropriate requisition.

SPECIAL CONSIDERATIONS:

REFERENCES:

Brunner and Suddarth (1988). Textbook of Medical-Surgical Nursing, (6th Edition). Philadelphia, PA: J.B. Lippincott, p. 668.

College of American Pathologists (1996). So You're Going to Collect a Blood Specimen. An Introduction to Phlebotomy. College of American Pathologists, Illinois.

Logston, Boggs, R., Woodridge-King, M. (1993). AACN Procedure Manual For Critical Care. Philadelphia, PA: W. B. Saunders Company.

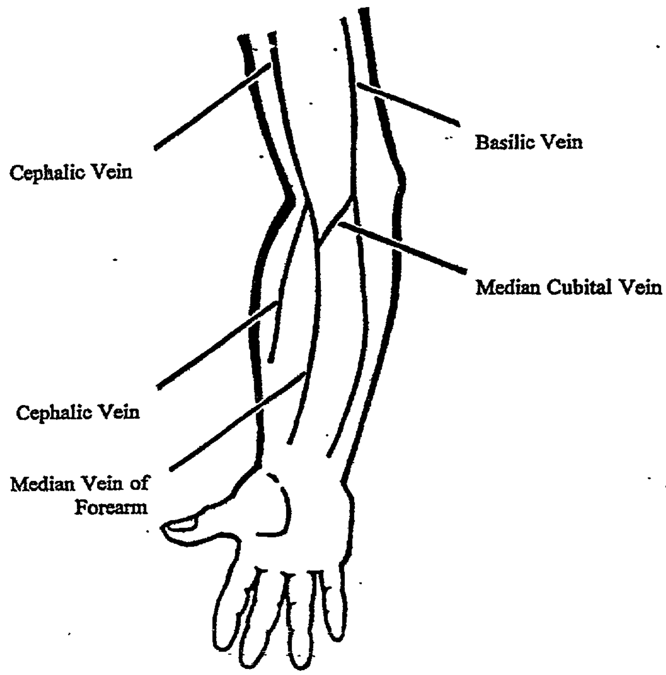
Milliam, Doris, A. (1987). Venous Blood Samples - Sharpen Your Drawing Skills. Nursing 87, December, p. 56 - 61.

Nursing Procedures, second edition, (1996). Sprintghouse. Springhouse, PA

EXPERT RESOURCES:	**PRACTICE AREA:**
Mary Liz Bilodeau, RNC, MS, CCRN Critical Care CNS	Department of Nursing
Martha Martin, RN, MSN Staff Specialist	Department of Nursing
Jill Pedro, RN, MSN, ONC Clinical Nurse Specialist	Department of Nursing

Approved: Council on Practice
Revised: Council on Practice

FIG. 12E



<u>FIGURE 1</u> - Major Veins in Upper Extremity

Name:	First	Initials	Last	Contact Telephone No.

Outward trip	mth	day	yr	time :	am/pm	Service Required:

From	To
Address	Address
State / Zip code	State / Zip code

Return trip	mth	day	yr	time :	am/pm	Service Required:

From	To
Address	Address
State / Zip code	State / Zip code

Notes on Required Nursing Services

Patient Information

Address:					
City:		State		Zip:	
Phone - Home:		Work:		Cell:	
email address:				Fax:	

Payment Guarantor Information

Name:	First	Initials	Last
Address:			
City:		State:	Zip:
Phone - Home:		Work:	Cell:
email address:			Fax:

Payment	Method					
Agreed fee for above services $	Cash		Credit Card Type	Amex		Visa
	Check		Card Number			
	Invoice Company		Issuer		Exp. Date	
	Other		Cardholder name shown on card			

FIG. 13

To receive a free and confidential quotation without obligation, please give the following information:

Name:	First	Initials	Last	Contact Telephone No:

Arrival date: mth / day / yr

Departure date: mth / day / yr

Total number in party:
adults:
children:

How will you travel to Boston?
Air
Rail
Car

Total rooms required:

Type of accommodation
- single room
- twin-bedded double
- family room
- junior suite
- parlor suite

Approximate nightly budget per room (excluding meals)
- $150 - $200
- $200 - $250
- $250 - $300
- $300 - $400
- $400+

please state any particular requirements:
(special meals, adapted bathrooms, wheelchair access etc.)

Near to any particular hospital? (if so please indicate which)

Address:

City: State: Zip:

Phone - Home: Work. Cell

email address: Fax:

FIG. 14

PATIENT REFERRAL INFORMATION

DATE:____/____/_____ REFERRED BY:

(name)______________________________

(Phone)______________________________

(Dept.)______________________________

(Email)______________________________

PATIENT NAME:___________________________

ADDRESS:____

PHONE:_____________________FAX:_________________CELL:_________________

DOB:__________________

DIAGNOSIS/PROCEDURE:

____

____

____

BRIEF MH/ALLERGIES:

____

____

____

____

ESTIMATED LENGTH OF STAY / TREATMENT:__________ days

REFERRING HOSPITAL ____

FLOOR________________UNIT________________ROOM NUMBER:_______________

SURGEON:_______________________PHONE:_________________FAX:__________

SERVICES TO BE PROVIDED:____

DATES/HOURS OF SERVICES: ____

Please check here to confirm that Page One/Two has been faxed

FIG. 15

PATIENT REFERRAL INFORMATION

DATE:____/____/_____ REFERRED BY: (Name)____________________
(Phone)____________________
(Dept.)____________________
(Email)____________________

PATIENT NAME:____________________________DOB:____________________________

ADDRESS:____

PHONE:______________________FAX:___________________CELL:___________________

DIAGNOSIS/PROCEDURE:____

BRIEF PMH/ALLERGIES:____

ESTIMATED LENGTH OF OUTPATIENT TREATMENT:______________ days/weeks/months

REFERRING HOSPITAL _________FLOOR____________ROOM NUMBER:____________

SURGEON/PHYSICIAN_________________PHONE:____________________FAX:__________

SERVICES
REQUESTED:____

START DATES/HOURS OF SERVICES: ____

Please check here to confirm that Page One/Two has been faxed

PAYMENT INFORMATION

Payment Guaranteed By:
Full Name:_______________________________ (Relationship to Patient)____________________

Address____ Tel.No:____________________

City_____________________ State__________ Zip___________ Email______________________

METHOD OF PAYMENT:____

CREDIT CARD DETAILS:____

EXACT NAME ON CARD__________________________________EXPIRATION DATE__________

FIG. 16A

SUPPLIES

Prescriptions to be filled/delivered _______YES (Please attach scripts) _______NO

Medical supplies needed: ______________________________

Medical/Adaptive equipment needed: ______________________________

CONCIERGE SERVICES

HOTEL

- ☐ Hotel preferences or price range:______________________________
- ☐ Number of Rooms:______________________________
- ☐ Number of Occupants;______________________________
- ☐ Arrival date/time:____________________(please note: most hotels have a 1p check in policy)
- ☐ Anticipated Date of Departure:______________________________

Room Preferences

BEDSIZE:______________SMOKING/NON:______________STANDARD/SUITE:______________

OTHER:______________________________

TRANSPORTATION:

- ☐ Nurse escort via car/airplane
- ☐ Wheelchair accessible van
- ☐ Ambulance
- ☐ Limousine
  - o Pick up date, time, location:______________________________

AESTHETIC SERVICES:

- ☐ Massage:______________________________
- ☐ Facial:______________________________
- ☐ Manicure:______________________________
- ☐ Pedicure:______________________________
- ☐ Makeup application:______________________________
- ☐ Hair Services (Cut/wash/perm/set):______________________________

SPECIAL REQUESTS:

____

____

____

____

FIG. 16B

FIG. 17

Patient Name____
DOB____

PHYSICIAN ORDERS

☐ New Admission Orders ☒ Monthly Renewal ☐ Telephone Order Verification
☐ Change in Plan of Care ☐ Change in Patient Status

DATE/ TIME	MEDICATIONS	TREATMENTS
	zantac 100 mg po BID	3° nursing care per day
	colace i po BID	
	glutamine powder 2 tbsp to	PT 1° q week
	TF	
	Pregestimil 30cal/oz 800 cc	
	over 10 hours over noc	
	via gt	

RN/Clinician's Signature____

Physician Name____ Address____

City, State, Zip____

Physician's Signature____ Date____

Reply:

2009050287 ′ 05006001

FIG. 18

MEDICATION RECORD

ALLERGIES_______________ Patient_______________

	MEDICATION			DATE	DATE	DATE	DATE	DATE	DATE	DATE
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							
START			AM							
D/C										
RED			PM							

INIT	SIGNATURE	INIT	SIGNATURE

FIG. 19A

PATIENT INTAKE FORM

PATIENT NAME:_____ DOB:_____

GUARDIAN NAME (IF CHILD):_____

PRIMARY PHYSICIAN:_____

DIAGNOSIS:_____

ALLERGIES:_____

CURRENT ADDRESS:_____

_____

LOCAL PHONE#/ CELLULAR/ PAGER:_____

RELIGION:_____

COUNRTY OF ORIGIN:_____

PERMANENT MAILING ADDRESS:_____

_____

PRIMARY LANGUAGE:_____

METHOD OF PAYMENT:_____

_____

SOURCE OF REFERRAL:_____

NAME AND # OF PERSON CALLING IN CASE:_____

_____

DATE OF ADMISSION:_____ DATE OF DISCHARGE:_____

START DATE OF SERVICES:_____

DOCTORS ORDERS: ______

ANTICIPATED LENGTH OF TREATMENT: ______

ADDITIONAL THERAPIES:

- ☐ OCCUPATIONAL THERAPY: ______
- ☐ PHYSICAL THERAPY ______
- ☐ SPEECH THERAPY: ______
- ☐ RESPIRATORY THERAPY: ______
- ☐ INFUSION SERVICES: ______
- ☐ ESCORTING TO APPOINTMENTS: ______
- ☐ SCHEDULE FOLLOW UP APPT: ______
- ☐ TRANSPORTATION: ______
- ☐ LIVING ACCOMODATIONS: ______
- ☐ OTHER: ______

DATE/TIME/SIGNATURE OF INTAKE WORKER: ______

PRIMARY NURSE ASSIGNED TO CASE: ______

FIG. 19B

10057087.050602

FIG. 20

CONCIERGE:

- ☐ **HOTEL:**________________________ARRIVAL:___________DEPARTURE:________

ROOM PREFERENCES:
BEDSIZE:_____________SMOKING:_______________STANDARD/SUITE:__________

OTHER PREFERENCES:____

- ☐ **TRANSPORTATION:**

PICKUP DATE/TIME/LOCATION:____

- ☐ **MEALS:**____
- ☐ **AESTHETIC SERVICES:**
  - ☐ MASAGE:____
  - ☐ FACIALS:____
  - ☐ MAINCURE:____
  - ☐ PEDICURE:____
  - ☐ MAKEUP APPLICATION:_________________________________
  - ☐ OTHER:____

COMMENTS:____
____
____
____
____
____
____

FOR OFFICE USE ONLY: (PLEASE INITIAL WHEN COMPLETED)

- ☐ STAFF ASSIGNED: ______
- ☐ HOTEL BOOKED: ______
- ☐ TRANSPORTATION CONFIRMED ______
- ☐ PATIENT NOTIFIED OF ALL DETAILS IN WRITING: ______
- ☐ CONTACT MADE WITH SURGICAL TEAM: ______
- ☐ PATIENT INVOICED: ______
- ☐ FOLLOW UP LETTER SENT TO PATIENT: ______
- ☐ FOLLOW UP LETTER SENT TO PHYSICIAN: ______

FIG. 21

VITAL SIGN RECORD

Patient________________

DATE/TIME	BP	TEMP/ ROUTE	HR	RR	COMMENTS	INITIALS

INIT	SIGNATURE	INIT	SIGNATURE

FIG. 22

INTAKE & OUTPUT

Patient Name____________________ **DOB**_______________________________

Allergies:____

INTAKE							OUTPUT						
DATE TIME	ORAL AMT	Subtotal	IV AMT	Subtotal	PG AMT	Subtotal	DATE TIME	URINE AMT	Subtotal	STOOL AMT	Subtotal	VOMIT AMT	Subtotal
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						
DAILY TOTAL							DAILY TOTAL						

PATIENT TIME SHEET: NURSING

FIG. 23

Month _____

Patient Name _____ Patient Signature _____

Location _____ Staff Signature _____

	Shift 1st					Shift					Shift				
Date of Mo	Nurse Name	Time In		Time Out		Total Hours	Nurse Name	Time In		Time Out		Total Hours	Nurse Name	Time In		Time Out		Total Hours
1			am pm		am pm				am pm		am pm				am pm		am pm	
2			am pm		am pm				am pm		am pm				am pm		am pm	
3			am pm		am pm				am pm		am pm				am pm		am pm	
4			am pm		am pm				am pm		am pm				am pm		am pm	
5			am pm		am pm				am pm		am pm				am pm		am pm	
6			am pm		am pm				am pm		am pm				am pm		am pm	
7			am pm		am pm				am pm		am pm				am pm		am pm	
8			am pm		am pm				am pm		am pm				am pm		am pm	
9			am pm		am pm				am pm		am pm				am pm		am pm	
10			am pm		am pm				am pm		am pm				am pm		am pm	
11			am pm		am pm				am pm		am pm				am pm		am pm	
12			am pm		am pm				am pm		am pm				am pm		am pm	
13			am pm		am pm				am pm		am pm				am pm		am pm	
14			am pm		am pm				am pm		am pm				am pm		am pm	
15			am pm		am pm				am pm		am pm				am pm		am pm	
	Totals																	

Applicant: Sternlicht

FIG. 24A

PHYSICAL THERAPY
Initial Evaluation

Date:

Name	Physician
Parent	Case Manager
Address	Primary PT
Date of Birth Gestational age	Chief complaint
Diagnosis	

SUBJECTIVE

PMH:

Social hx

Prior level of functioning:

Precautions:

Hx of present illness:

Pain

Medications

MUSCULOSKELETAL ASSESSMENT

Joint range of Motion ☐WNL

Motion	Position	Mon		Arom	
		Right	Left	Right	Left

Muscle Strength ☐WNL

Muscle	Position	Grade	
		Right	Left

Muscle Tone

Sensory

REFLEX PROFILE

Supine

Prone

Sitting

Quadruped

Standing/vertical Suspension

Horizontal Suspension

FIG. 24B

Prone	
Supine	
Sitting	
Quadruped	
Kneeling	
Half Kneeling	
Standing	
Ambulation	
Stair Climbing	
Ball Skills	

Balance		**Static**	**Dynamic**
	Standing		
	Sitting		

FIG. 24C

FINE MOTOR ASSESSMEI
Focus/Visual Tracking
Approach
Grasp
Manipulation
Release
Transferring
Bilateral Activities
ACTIVITIES OF DAILY LIVING
Feeding
Dressing
Hygeine

FIG. 24D

EQUIPMENT

SUMMARY

Assessment:

Problems:

Plan of Care:

Goals:

Expected Visits

Signature__________________________PT Date________________

FIG. 24E

FIG. 25

PATIENT TIME SHEET: THERAPY VISITS

Month ____________

Patient Name ____________ Patient Signature ____________

Location ____________ Staff Signature ____________

	SHIFT 1				SHIFT 2				SHIFT 3			
Date of Mo	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours
1		am pm	am pm			am pm	am pm			am pm	am pm	
2		am pm	am pm			am pm	am pm			am pm	am pm	
3		am pm	am pm			am pm	am pm			am pm	am pm	
4		am pm	am pm			am pm	am pm			am pm	am pm	
5		am pm	am pm			am pm	am pm			am pm	am pm	
6		am pm	am pm			am pm	am pm			am pm	am pm	
7		am pm	am pm			am pm	am pm			am pm	am pm	
8		am pm	am pm			am pm	am pm			am pm	am pm	
9		am pm	am pm			am pm	am pm			am pm	am pm	
10		am pm	am pm			am pm	am pm			am pm	am pm	
11		am pm	am pm			am pm	am pm			am pm	am pm	
12		am pm	am pm			am pm	am pm			am pm	am pm	
13		am pm	am pm			am pm	am pm			am pm	am pm	
14		am pm	am pm			am pm	am pm			am pm	am pm	
15		am pm	am pm			am pm	am pm			am pm	am pm	
	Totals											

FIG. 26

PHYSICIAN MEMORANDUM

Date:__________________

Physician:______________________________Office/Fax:________________________

Patient:_______________________________________DOB:______________________

☐ **Patient Status Update** ☐ **Additional Service Request**

☐ **Orders** ☐ **Other**

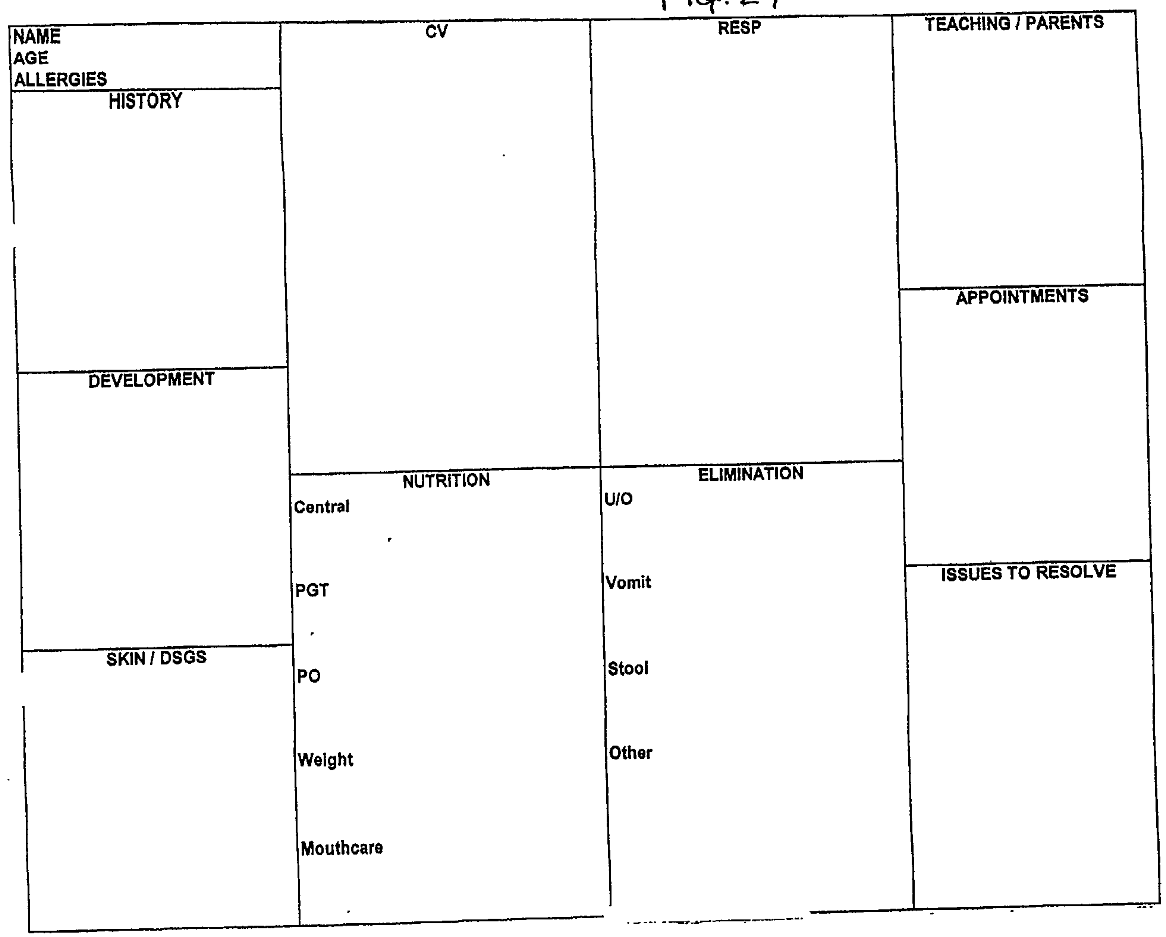
Comments:

R.N./Clinicians Name___________________________Contact Number:________________

Reply:

Physician's Signature:____________________________________**Date:**____________________

FIG. 27



NAME
AGE
ALLERGIES
HISTORY
DEVELOPMENT
SKIN / DSGS
CV
NUTRITION
Central
PGT
PO
Weight
Mouthcare
RESP
ELIMINATION
U/O
Vomit
Stool
Other
TEACHING / PARENTS
APPOINTMENTS
ISSUES TO RESOLVE

FIG. 28A

TO BE COMPLETED BY THE PATIENT, FAMILY MEMBER OR NURSE	FOR NURSE USE ONLY
1. What language do you speak? ______ 2. Why do you need home care services? ______ 3. Do you have ALLERGIES to medicines/ latex/ food? If yes, list ______ ______ 4. What is the hospital you are being treated at? ______ 5. Who is your primary doctor? ______ 6. Are there other doctor's involved in your care?- ______ ______ 7. Do you smoke? ☐ no ☐ yes How much? ______ 8. Do you use recreational drugs? ☐ no ☐ yes How much? ______ 9. Do you use alcohol? ☐no ☐ yes How much? ______ 10. Please list all medications you are presently taking below	HEALTH PERCEPTION MANAGEMENT ☐ Needs health teaching ☐ Needs med teaching

Medication	Dose	Purpose

11. Do you have enough information about your medications? ☐ no ☐ yes	
12. Do you have any problems with your bowels? ☐ no ☐ yes Please describe ______ ______ 13. Do you have any problems with urinating? ______ ______	ELIMINATION ☐Needs output regimen
14. Do you have any problems with your intake of food? (eating, swallowing, chewing, nausea/vomiting)? ☐ no ☐ yes Please describe ______ ______ 15. Do you follow any special diets? ☐ no ☐ yes Please describe ______ ______ 16. Does you have any skin problems? (rashes, bruises, reactions, cut, bumps)? ☐ no ☐ yes Please describe ______ ______	NUTRITION/ METABOLIC ☐ Needs nutrition teaching ☐ Needs nutrition material
17. Are there any limitations to your activities? ☐ no ☐ yes Describe ______ ______ 18. Do you need assistance with any daily activities? ☐ no ☐ yes Describe ______ ______ 19. Do you have or need any special equipment? ☐ no ☐ yes Describe ______ ______	ACTIVITY/EVERCISE ☐ PT needed ☐ OT needed

20. Do you have any problems sleeping? ☐ no ☐ yes Describe_____ 21. Do you have enough energy for your daily activities? ☐ no ☐ yes Describe	SLEEP/REST
22. Do you have any problems with ☐ memory ☐ vision ☐ hearing? Describe	COGNITIVE/ PERCEPTUAL
23. Do you any questions or concerns about your sexuality/reproductive system? ☐ no ☐ yes List_____	SEXUALITY/ REPRODUCTIVE
24. How are you coping with your health issues at the present time?_____	COPING/STRESS
25. Has your illness changed your life significantly? ☐ no ☐ yes Deacribe_____	SELF PERCEPTION
26. Who are the important people to be involved in your care?_____ 27. Who shall we contact in the event of any emergency?_____ Telephone_____ 28. Do you have a health care proxy? ☐ no ☐ yes name_____	ROLE/RELATIONSHIP ☐ Proxy in chart
29. Are there any religious practices that we can support? ☐ no ☐yes Describe_____	VALUE/BELIEF
30. Are there any needs medically and personally that we can assist you with? ☐ no ☐ yes List_____	
NURSING ISSUES TO BE ADDRESSED Information obtained from_____ Nursing Signature _____ Date_____	

FIG. 29

Progress Note

Patient Name:	Age:	Allergies:	Physician: